DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 10/24/12

PRINTED: 09/13/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445498 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 09/10/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRISTOL NURSING HOME | 261 NORTH STREET<br>BRISTOL, TN 37625 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 015 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. (In fully sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1, 19.3.3.2<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, the facility failed to assure room interior surface finishes had a flame spread rating of C or less.<br>The findings include:<br>Observation and interview with the Maintenance Director, on September 10, 2012 at 12:45 p.m. confirmed the walls in the 2nd floor clean linen room were covered with wood paneling. There was no documentation provided indicating it as Class A, B, or C.<br>This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on September 10, 2012. | K 015 | K 015<br><br>No residents were affected.<br><br>All residents had the potential to be affected.<br><br>Walls in the second floor clean linen room will be painted with a fire retardant paint by maintenance on 9/28/12.<br><br>Paint information will be added to the next Quality Assurance Committee meeting minutes and a copy will be kept on file in the maintenance office.<br><br>The Quality Assurance Committee (Administrator, Director of Nursing, and Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Manager, Social Services Director, Maintenance Director, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved. | completed 10/22/12 |
| K 050 SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine.<br>Responsibility for planning and conducting drills is assigned only to competent persons who are | K 050 | K 050<br><br>No residents were affected.<br><br>All residents had the potential to be affected.<br><br>A fire drill log was created to ensure drills are carried out timely. | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Christopher A. Goddy | Administrator | 9/24/12 |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/13/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445498 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 09/10/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRISTOL NURSING HOME | 261 NORTH STREET<br>BRISTOL, TN 37625 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 050 | Continued From page 1<br>qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, the facility failed to assure fire drills were conducted quarterly on each shift .<br>The findings include:<br>Record review on September 10, 2012 at 1:50 p.m. confirmed the night shift failed to perform a fire drill the 1st quarter of 2012.<br>This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on September 10, 2012. | K 050 | Maintenance will be educated by the CEO that fire drills are to be carried out at random times at least quarterly on each shift and the date and time placed on the fire drill log by 9/21/12.<br><br>Any fire drills performed will be brought to the CEO for signature.<br><br>Fire drills will be reported in the Quality Assurance Committee by the Maintenance Director on a quarterly basis.<br><br>The Quality Assurance Committee (Administrator, Director of Nursing, and Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Manager, Social Services Director, Maintenance Director, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved. | |
| K 067<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2<br><br>This STANDARD is not met as evidenced by:<br>NFPA 90A, 3-4.7 Maintenance - At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary.<br>Based on observation, interview and record | K 067 | K 067<br><br>No residents were affected.<br><br>All residents had the potential to be affected.<br><br>Bids are being obtained to get fire dampers cleaned in the building.<br><br>A fire damper cleaning log was created to keep track of the cleaning schedule.<br><br>The fire damper cleaning log will be reviewed in the Quality Assurance Committee meeting on an annual basis. | completed 10/22/12 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/13/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445498 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 09/10/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRISTOL NURSING HOME | 261 NORTH STREET<br>BRISTOL, TN 37625 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 067 | Continued From page 2<br>review, the facility failed to assure fire dampers were maintained in accordance with NFPA 90A.<br>The findings include:<br>Record review and interview with the Maintenance Director on September 10, 2012 at 1:30 p.m. confirmed the facility failed to perform the 4-year required maintenance to fire dampers.<br>Observation of supply air ducts on September 10, 2012 between 9:45 a.m. and 1:30 p.m. confirmed the ducts had a heavy accumulation of lint in them<br>These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on September 10, 2012. | K 067 | The Quality Assurance Committee (Administrator, Director of Nursing, and Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Manager, Social Services Director, Maintenance Director, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved. | completed 10/22/12 |
| K 073<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br>No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to assure combustible decorations were fire retardant (NFPA 110, 19.7.5.4).<br>The findings include:<br>Observation and interview with the Maintenance Director, on September 10, 2012 at 11:20 a.m. confirmed the facility failed to provide documentation that the grass-like hanging decorations in the 2nd floor activity room was treated with fire retardant material.<br>This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on September 10, 2012. | | K 073<br>No residents were affected.<br><br>All residents had the potential to be affected.<br><br>Maintenance will do a complete check of the building for combustible decorations any found will be treated.<br><br>Maintenance will do monthly checks of combustible decorations to ensure all decorations have been treated.<br><br>The monthly checks will be monitored in the Quality Assurance Committee by the Maintenance Director on a quarterly basis.<br><br>The Quality Assurance Committee (Administrator, Director of Nursing, and Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Manager, Social Services Director, Maintenance Director, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved. | completed 10/22/12 |
| K 144 | NFPA 101 LIFE SAFETY CODE STANDARD | K 144 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/13/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445498 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 09/10/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRISTOL NURSING HOME | 261 NORTH STREET<br>BRISTOL, TN 37625 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 144 SS=F | Continued From page 3<br>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to assure the emergency generator was run for 30 minutes under load each month at a frequency of 20 - 40 days apart.<br>The findings include:<br>Record review of the Emergency Generator logs with the Maintenance Director, on September 10, 2012 at 1:00 p.m. confirmed the Generator was not run under load from January 19, 2012 to May 18, 2012.<br>This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on September 10, 2012. | K 144 | K 144<br><br>No residents were affected.<br><br>All residents had the potential to be affected.<br><br>The maintenance staff will be educated by the CEO on the need to exercise the generator under load monthly by 9/28/12.<br><br>Monthly generator test will be brought to the CEO for signature.<br><br>Monthly generator test will be discussed in the Quality Assurance Committee on a monthly basis for one year.<br><br>The Quality Assurance Committee (Administrator, Director of Nursing, and Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Manager, Social Services Director, Maintenance Director, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved. | Completed 10/22/12 |